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Health Care Law

Navigating Hospital Provider-Based Billing

Implications for cost, quality, efficiency and community benefits

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Bolstered by the Supreme Court's landmark decision in *National Federation of Independent Business v. Sebelius*, 132 S.Ct. 2566 (June 28, 2012), the movement toward affiliation as a means of improving quality is continuing unabated. Accountable Care Organizations (ACOs), a concept created under the Affordable Care Act and further refined in lengthy regulations and guidance, are one method of achieving the benefits of care coordination. Hospital acquisition of physician practices, however, provides another alternative. In March of 2011, the Medicare Payment Advisory Commission (MedPAC) reported to Congress that hospital-based outpatient physician office visits grew by 9 percent from 2008 to 2009, representing a quarter of all hospital outpatient volume growth.

Hospitals are buying or otherwise affiliating with physician practices in epic proportions in an effort to expand service lines and service areas. Physicians, facing higher expenses, dwindling reimbursement and greater administrative costs, are jumping on board, eager to gain the financial stability that affiliation is likely to provide. Depending on the services offered by the practice, a hospital purchaser may receive significantly greater reimbursement if the services are billed under the hospital's provider number, as opposed to under the Medicare Physician Fee Schedule. A hospital can only bill the services as "provider-based" if the practice meets the Medicare provider-based billing rules. Otherwise, the services must be billed on a free-standing basis. Navigating these provider-based billing rules demands careful vigilance, however, and should be undertaken with a careful eye for hidden hazards.

Provider-Based Billing Rules

Generally, Medicare reimburses hospitals more favorably than physicians or other suppliers for the same services. This makes sense. Medicare Conditions of Participation for hospitals contain onerous requirements which can greatly increase a hospital's operational expenses. Moreover, the Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to treat patients with emergency medical conditions regardless of their ability to pay. Finally, payment for inpatient services may understate the costs of providing such services, while payment for hospital outpatient services may make up some of the difference.

Effective Oct. 1, 2002, the Centers for Medicare and Medicaid Services (CMS) promulgated regulations, at 42 CFR §413.65, to set forth criteria for determining whether a hospital can appropriately bill services as provider-based. Services provided on a hospital campus or by a department of the hospital will not be assumed to be provider-based unless they meet the requirements for on-campus provider-based entities. Off-campus facilities are subject to additional standards designed to ensure that they are integrated with the main hospital despite their off-campus location. In addition, 42 CFR §413.65(b)(4) states that if a facility is not located on the campus of a hospital and if it provides services of the kind usually furnished in physician offices, it is presumed to be a free-standing facility, unless CMS determines the facility has provider-based status.

To achieve provider-based status, a facility/organization must be clinically and financially integrated with the main hospital. Following is a summary of the key components of the provider-based entity

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standards that must be met.

• *Licensure*: Services are provided under the hospital's license, except in states that require a separate license or in states that do not require licensure. A letter confirming licensure exemption must be obtained to verify this.

• *Clinical Integration*: The facility's clinical services are integrated as evidenced by: (a) professional staff of the facility having clinical privileges at the hospital; (b) the reporting and monitoring relationship between the facility's medical director and the hospital's chief medical officer; (c) medical staff committees being responsible for the medical activities at the facility, including quality assurance and utilization review; (d) medical records being integrated into the hospital's system; and (e) patients of the facility who need further care having access to all services of the hospital and being referred, where appropriate, to the corresponding inpatient or outpatient department/service of the hospital.

• *Financial Integration*: The financial operations of the facility are integrated within the financial system of the hospital, as evidenced by shared income and expenses and on hospital cost reports.

• *Public Awareness*: Signage and other public awareness at the facility must make it evident that it is a hospital location.

• *Obligations of Hospital Outpatient Departments*: The facility must fulfill all obligations of other hospital departments, including antidumping obligations under EMTALA if it is located on the hospital's campus or if it is a dedicated emergency department and nondiscrimination requirements. All Medicare patients must be treated as hospital outpatients.

Off-campus facilities are subject to additional requirements that legally and operationally integrate them into the hospital. Generally, they must be located no more than 35 miles from the campus of the hospital and be fully owned by the hospital with the same governing body and under the same organizational documents. The hospital must have final responsibility for all administrative, contracting, personnel policies and medical staff appointments. In addition, an off-campus facility seeking provider-based status must be administratively integrated, with a reporting relationship to the hospital that does not differ from that of any other hospital department.

Specific Issues for Structuring Provider-Based Entities

• *Management Contracts*. Off-campus locations that seek provider-based status and are *operated under management contracts* must meet further requirements located at 42 CFR §413.65(h). Many providers find the most vexing of these to be the requirement that all staff of the facility who directly provide patient care services, which are not paid for by Medicare under a fee schedule, must be employed by the hospital.

This requirement is particularly troublesome in the case of newly acquired physician practices that are under contract with a specialty provider to run their physical therapy, nuclear technology, cardiac testing or other services. In such cases, it may be necessary upon acquisition for the hospital to substitute its own direct employees for those of the specialty provider, including technicians with hands-on responsibilities.

On-campus locations are not subject to the prohibition. CMS, however, strictly interprets the requirement that the on-campus facility/organization be located no more than 250 yards from the hospital's main building.

The determination as to whether hospital employment of direct care personnel is mandatory rests on whether the off-campus facility is, in fact, operated under management contracts. Arguably, a single service line location would be operated under a management contract if that service was operated by the specialty provider. If, however, physician services are also provided and those services are offered and managed by the hospital, as opposed to the third-party specialty service "manager," a question arises as to whether the location is, in fact, being operated under management contracts. A good argument can be made that it is not: while one service provided at the facility may be operated under a management contract, the entire facility is not.

• *Under Arrangements*. Alternatively, a facility providing specialty services managed and staffed by a third party could avoid the employment requirement by asserting that the specialty service is actually being provided by a third party "under arrangement" with the hospital to its patients. The provider-based rules state that a facility *may* not qualify for provider-based status if all services are provided under arrangements. 42 CFR §413.65(i). Regardless of whether that is interpreted as an all-out prohibition or posing the possibility of being denied provider-based status on that basis, it is clear that the provider-based regulations do not prohibit providers from offering select or specialized services under arrangements at off-site locations. Moreover, unlike the provider-based rules, under arrangements are specifically authorized by statute. See 42 U.S.C. § 1395x(w) (definition of "under arrangements").

In commentary to the provider-based regulations, CMS noted that "a provider that operates a facility legitimately as provider-based may choose to obtain some specialized services for its patients under arrangements without needing to meet the management contracts requirements of § 413.65(h) with respect to each individual service," and went on to state that "[the management contracts requirements] apply to facilities, not to individual services." 67 Fed. Reg. 49981, 50091 (Aug. 1, 2002).

A keystone of the "under arrangements" concept is that a hospital's compensation to the provider must discharge the liability of the beneficiary to pay for the service. Moreover, the hospital cannot merely act as a billing mechanism but must exercise professional responsibility over the arranged-for service. Despite statutory authority for under arrangements, the Medicare provider-based rules (as well as recent changes to the fraud and abuse regulations) have made hospitals gun shy about relying on the concept of an under arrangement. CMS stated, in its commentary to the regulations, that "[it] continue[s] to believe it would be inappropriate for a facility, whether located on or off campus, to evade the provider-based requirements by claiming to provide all of its services under arrangements."

The push toward care coordination in an effort to increase quality continues unabated. Affiliation has the added benefits of expanding service lines, patient access and sources of funding for expensive technology — including electronic medical records. Physician practice acquisition is the most basic way a hospital can ensure that its patients receive the primary medical care they need. Exploring provider-based status is an important step toward the successful structuring of such viable patient care alternatives. ■